

GEORGIA STATE BOARD OF WORKERS' COMPENSATION**INDIVIDUALIZED REHABILITATION PLAN**

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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SECTION 1 IDENTIFYING INFORMATION

EMPLOYEE	Occupation	Catastrophic Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	County of Injury	Birthdate
	Diagnosis & Functional Restrictions			

SECTION 2 PLAN INFORMATION

(Please check the appropriate blocks)

☐ Initial Plan

Date Last Plan Submitted

TYPE OF PLAN:

- | | |
|---|---|
| <input type="checkbox"/> Medical Care Coordination
(Catastrophic Cases Only) | <input type="checkbox"/> Vocational Services (select one) |
| <input type="checkbox"/> Independent Living | <input type="checkbox"/> RTW / Same Employer |
| <input type="checkbox"/> Extended Evaluation | <input type="checkbox"/> Job Modification |
| | <input type="checkbox"/> Graduated |
| | <input type="checkbox"/> Placement |
| | <input type="checkbox"/> On-the-Job Training |
| | <input type="checkbox"/> Formal Training |
| | <input type="checkbox"/> Self-Employment |

The Following Documentation is Submitted for Plan Approval:

- | | |
|--|--|
| <input type="checkbox"/> Initial Rehabilitation Report | <input type="checkbox"/> Release to RTW |
| <input type="checkbox"/> Pain / Psychological Reports | <input type="checkbox"/> Physical Restrictions |
| <input type="checkbox"/> Rehabilitation Narrative Report | <input type="checkbox"/> Physical Capacities |
| <input type="checkbox"/> Physicians' Approval of Job | <input type="checkbox"/> Analysis of Offered Job |
| <input type="checkbox"/> Job Analysis at Time of Injury | <input type="checkbox"/> Vocational Evaluation |
| <input type="checkbox"/> Transferable Skills Analysis | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Summary of Labor Market Survey | |
| <input type="checkbox"/> Medical Narrative Report | |

Give a statement (individualized to this case) as to why services of a rehabilitation supplier are needed:

Complete this Information for an amended plan:

Type of Original Plan	Date of Original Plan	Type of Previous Amended Plan	Date
If Services were interrupted in the Original / Amended Plan, state reason		If Services are to be a continuation of a Previous Plan, state the need and justification for continuation	

SECTION 3 COMPLETE THIS PART FOR THE CHECKED TYPE OF PLAN

- | | | |
|---|---|--|
| <input type="checkbox"/> Medical Care Coordination
(catastrophic cases only) | <input type="checkbox"/> Independent Living | <input type="checkbox"/> Extended Evaluation |
|---|---|--|

State Specific Problems	State Specific Goals

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION**SECTION 4 COMPLETE THIS PART FOR CHECKED VOCATIONAL SERVICES**

1.

- ☐ Job Modification
☐ Graduated
☐ RTW
☐ Placement
☐ OJT
☐ Formal Training

State Reasons for Type of Plan Selected:

2. Complete Work and Wage Information:

Average Weekly Wage at Time of Injury \$ _____ or per Hour _____ Anticipated Wages \$ _____ per Week

Wage Loss \$ _____ Hours Worked per Week at Time of Injury _____

Proposed Full Time Work _____ or Part Time Work _____

3. State Occupational Objectives:

4. List Educational / Vocational Background:

5. Occupational Objectives Determined by:

☐ Transferable Skills☐ Vocational Evaluation

Date

Determined by:

Date

Evaluator

Summary of Vocational Evaluation:

6. Summary of Labor Market Survey (attach report) :

Date Completed

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SECTION 5 SERVICES AND RESPONSIBILITIES REQUIRED TO MEET GOALS

State Services/Responsibilities

Completion Date

Payer

Total Cost of Proposed Plan:

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION**SECTION 6 CERTIFICATE OF SERVICE**

☐ I certify that I have discussed this plan with the employee and other parties to the case and have mailed copies on _____ / _____ / _____ to the following parties at the current Addresses below.
 _____ Month _____ Day _____ Year

Signature		Registration No.	
Rehabilitation Supplier Name	Telephone	Address	
E-mail Address	City	State	Zip Code

EMPLOYEE	Last Name	First Name	M.I.	Address		
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYER	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
INSURER / SELF-INSURER	Name			Address		
CLAIMS OFFICE	Name					
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYEE'S ATTORNEY	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYER'S ATTORNEY	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
SITF	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code

Employee Comments about this plan:

Employee Signature (This indicates you have read or have had read to you the plan, not that you agree with the plan)

Date

Is this case applicable for Kid's Chance scholarships? ☐ Yes ☐ No If yes, submit application to Kid's Chance, Inc.

SECTION 7 APPROVAL / OBJECTIONS, TWENTY (20) DAY NOTICE

Absent written objections within 20 days of the date mailed, the rehabilitation request is approved effective the date of the certificate of service. No further correspondence will be issued by the Board. If there is an objection:

- (1) The Objection must be in writing.
- (2) It must be received by the Georgia State Board of Workers' compensation within 20 days of the date of the Certificate of Service.
- (3) A Certificate of Service must be completed stating that copies of the written objections were placed in the mail to all parties and the principal rehabilitation supplier the same date as the Certificate of Service.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.georgia.gov>

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